APPENDIX J-1

CLAIM PREPARATION AND MAILING INSTRUCTIONS FOR FORM DPA 1443, PROVIDER INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed character per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Appendix J-1a is a copy of Form DPA 1443, Provider Invoice. Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. Appendix O-1b provides instructions for completion of Medicare/Medicaid combination claims.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.
Conditionally Required	=	Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable.

COMPLETION	**ITEM EXPLANATION AND INSTRUCTIONS**
Required	**1. Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2. Provider Number** - Enter the Provider Number exactly as it appears on the Provider Information Sheet.
Conditionally Required	**3. Payee** - This entry is required when the provider has more than one potential payee. Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.

If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.

Conditionally Required	**4. Group** - An entry is required only when you specify a "pay to" address on enrollment. Enter the appropriate payee number of the group as shown on the Provider Information Sheet.
Not Required	5. Role - Leave blank.
Not Required	6. Acc/Inj - Leave blank.
Optional	**7. Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to the provider.
Optional	**8. Provider Street** - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If address is not entered, the Department will not attempt corrections.
Conditionally Required	**9. Facility & City Where Service Rendered** - This entry is required when Place of Service Code in Field 28 (Service Sections) is other than K (patient's home) or A (provider's office).
Conditionally Required	**10. Prior Approval** - Enter the unique number from the computer generated prior approval notification, when billing for an item or service which approval has been obtained.
Optional	**11. Provider City State Zip** - Enter city, state and zip code of provider. See Item 8 above.
Required	**12. Referring Practitioner Name** - Enter the name of the physician who requested services to be provided.
Required	**13. Ref. Prac. No.** - Enter the State License Number, AMA Number or Social Security Number of the physician who requested services be provided.
Required	**14. Recipient Name** - Enter the patient's name exactly as it appears on the MediPlan Card or Temporary MediPlan Card or KidCare Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.

Required

15. Recipient No. - Enter the nine digit number assigned to the individual as copied from the MediPlan Card or Temporary MediPlan or KidCare Card. Use no punctuation or spaces. Do not use the Case Identification Number.

If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.

Optional

16. Birthdate - Enter the month, day and year of birth of the patient as shown on the MediPlan Card or Temporary MediPlan Card or KidCare Card. Use the MMDDYY format

Not Required

17. Healthy Kids - Leave blank.

Not Required

18. Fam Plan - Leave blank.

Not Required

19. Cr. Child - Leave blank.

Not Required

20. St/Ab - Leave blank.

Required

21. Billing Date - Enter the date the Provider Invoice was prepared. Use MMDDYY format.

Required

22. Primary Diagnosis - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment.

Required

23. Prefix - When the diagnosis code has an alphabetic prefix of E or V, enter it here

Required

24. Diag. Code - Enter the ICD-9-CM code for the primary diagnosis entered in Item 22.

Not Required

25. Secondary Diagnosis - Leave blank.

Not Required

26. Prefix - Leave blank.

Not Required

27. Diag. Code - Leave blank.

28. Service Sections: Complete one service section for each item or service provided to the patient.

Required — **Procedure Description/Drug Name** - Enter the appropriate description of the service provided or item dispensed.

Required — **Proc. Code/Drug Item No.** - Enter the appropriate procedure code.

Conditionally Required — **Delete** - When an error has been made that cannot be corrected enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.

Required — **Date of Service** - Enter the date the service was performed. Use MMDDYY format.

Required — **Cat. Serv.** - Enter the appropriate Category of Service code.

11 Physical Therapy Services
12 Occupational Therapy Services
13 Speech Therapy/Pathology Services

Required — **Place of Serv.** - Enter the one letter Place of Service code from the following list:

Code:	**Place of Service**:
A	Provider's Office
C	Outpatient Hospital
H	Long Term Care Facility
I	Sheltered Care Facility
K	Patient's Home

Required — **Units/Quantity** - Enter the units of time covered by the therapy session. Fifteen minute intervals equal one (1) unit, e.g., 0-15 equals 1 unit; 16-30 equals 2 units; 31-45 equals 3 units; 46-60 equals 4 units. A maximum of 4 units are allowed per date of service for therapy. A maximum of 8 units are allowed for children evaluations

Not Required — Modifying Units - Leave blank.

Conditionally Required

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required.

When the date of service is the same as the "Spenddown Met" date on the DPA 2432 (Split Billing Transmittal) attach the DPA 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form DPA 2432 shows a recipient liability greater than $0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	the actual recipient liability as shown on Form DPA 2432.
TPL Date	the issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

If Form DPA 2432 shows a recipient liability of $0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	the issue date on the bottom right corner of the DPA 2432. This is in MMDDYY format.

Conditionally Required

Status - If a TPL code is shown in the previous item, a two digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is 000 or blank.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met: TPL status code 04 is to be entered when the patient's Form DPA 2432, Split Billing, shows $0.00 liability.

05 - Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

TPL Amount - If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box.

Conditionally Required

Adjudication Date - A TPL date is required when any status code is shown in Item 28J. Use the date specified below for the applicable code:

Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the DPA 2432
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required

Repeat - Leave blank.

Not Required

29. Optical Materials Only - Leave blank.

Charges and Deductions Section (**Unlabeled**) - The information field in the lower right of the Provider Invoice is to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If a second third party resource was identified for one or more of the services billed in service sections 1 through 7 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

Conditionally Required	**Sect. #** - If more than one third party made a payment for a particular service, enter the service section number (1 through 7) in which that service is reported. If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 30 will be applied to the total of all service sections on the Provider Invoice.
Conditionally Required	**TPL Code** - Enter the appropriate TPL Resource Code referencing the source of payment (General Appendix 9). If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in the Uncoded TPL Name field.
Conditionally Required	**Status** - Enter the appropriate TPL Status Code. See the Status field in Item 28 above for correct coding of this field.
Conditionally Required	**TPL Amount** - Enter the amount of payment received from the third party resource.
Optional	**Adjudication Date** - Enter the date the claim was adjudicated by the third party resource. (See the Adjudication Date field in Item 28 above for correct coding of this field.)
Conditionally Required	**Uncoded TPL Name** - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required	**Total Charge** - Enter the sum of all charges submitted on the Provider Invoice in service section 1 through 7.
Required	**Total Deductions** - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).
Required	**Net Charge** - Enter the difference between Total Charge and Total Deductions.

Required	**31. # Sects** - Enter the total number of service sections completed correctly in the top part of the form. This entry must be at least one and no more than 7. Do not count any sections which were deleted because of errors.
Not Required	32. Original DCN - leave blank.
Not Required	33. Original Voucher Number - leave blank.
Required	**Provider Certification, Signature and Date** - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered.

MAILING INSTRUCTIONS

The Provider Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The copy of the claim is to be retained by the provider.

The pin-feed guide strip should be detached from the sides of continuous feed forms.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

- Form DPA 1411, Temporary MediPlan Card
- Any other document

APPENDIX J-1a
Reduced Facsimile of Form DPA 1443, Provider Invoice

PROVIDER INVOICE
ILLINOIS DEPARTMENT OF PUBLIC AID

IDPA USE ONLY

ELITE PICA

TYPEWRITER ALIGNMENT
<----------**USE CAPITAL LETTERS ONLY**----------> ELITE PICA

NNN

1. PROVIDER NAME (First, Last) | 2. Provider Number | 3. Payee | 4. Group | 5. Role | 6. Acc/Inj | 7. Provider Reference

8. Provider Street | 9. Facility and City Where Service Rendered | 10. Prior Approval

11. Provider City | 12. Referring Practitioner Name (First, Last) | 13. Ref. Prac. No.

14. Recipient Name, (First, MI, Last) | 15. Recipient Number | 16. Birthdate | 17. H Kids | 18.Fam Plar | 19 Cr Child | 20 St/Ab | 21. Billing Date

22. Primary Diagnosis | 23. Prefix | 24. Diag. Code

25. Secondary Diagnosis | 26. Prefix | 27. Diag. Code

28. Service Sections

1
Procedure Description / Drug Name, Form and Strength or Size | Proc. Code/Drug Item No. | Delete

Date of Service | Cat. Serv. | Place of Serv | Units/Quanty | Modifying Units | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Provider Charge

2
Repeat | Procedure Description / Drug Name, Form and Strength or Size | Proc. Code/Drug Item No. | Delete

Date of Service | Cat. Serv. | Place of Serv | Units/Quanty | Modifying Units | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Provider Charge

Note: Center section of form has been removed to enlarge detail. The actual form has 7 Service Sections.

7
Repeat | Procedure Description / Drug Name, Form and Strength or Size | Proc. Code/Drug Item No. | Delete

Date of Service | Cat. Serv. | Place of Serv | Units/Quanty | Modifying Units | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Provider Charge

29. OPTICAL MATERIALS ONLY

Sec # | TPL Code | Status | $ TPL Amount | Adjudicaton Date | $ Total Charges

Sec # | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Total Deductions

Sec # | TPL Code | Status | $ TPL Amount | Adjudication Date | $ Net Charges

31. # Sects | 32. Original DCN | 33. Orig Voucher # | Uncoded TPL Name

My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from this patient or any other third party will be properly credited or paid to the Illinioins Department of Public Aid; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program , as provided under Title XIX of the Social Security Act and applicable State statutes; I provided or directly supervised all services for which a charge appears; I understand

payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and consideration specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.

Signature | Date

DPA 1443 (R-1-91) Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form Approved by the Forms Management Center. IL478-1210

APPENDIX J-1b
PREPARATION AND MAILING INSTRUCTIONS FOR MEDICARE/MEDICAID COMBINATION CLAIMS

Chapter 100, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of co-insurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Intermediary or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare intermediary on Form HCFA 1500. The words "Illinois Department of Public Aid" or "IDPA" and the patient's nine digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In many instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare intermediary automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code indicating that the claim has been sent to the Department. The claim will appear later on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- payment is made by the Medicare intermediary but the EOMB does not show that the claim has been crossed over, or
- when more than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice.

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- the provider name in Field 33 exactly as it appears on the Provider Information Sheet,
- the provider's Provider Number in the lower right hand corner of Field 33, and
- the one digit provider payee code (if the provider has multiple payees listed on the Provider Information Sheet) in Field 33 immediately following the Provider

Name.

If the HCFA 1500 submitted to Medicare lists services of two or more practitioners, a separate claim and EOMB is required for each. In addition, the services provided by each practitioner must be identified.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

The Department's liability for payment is generally based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine if submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare intermediary. If the provider has requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form DPA 1443 with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached.

APPENDIX J-2

PREPARATION AND MAILING INSTRUCTIONS FOR FORM DPA 1409, PRIOR APPROVAL REQUEST

Form DPA 1409, Prior Approval Request, is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

Form DPA 1409 is a multi-part form. Appendix J-2a contains an example of the form.

INSTRUCTIONS FOR COMPLETION

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:		
Required	=	Entry always required.
Conditionally Required	=	Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable; leave blank.

ITEM EXPLANATION AND INSTRUCTIONS

Not Required	1.	Trans Code (Transaction Code) - Leave blank.
Not Required	2.	Prior Approval Number - Leave blank.
Required	**3.**	**Case Name** - Enter the case name from the patient's Medical Eligibility Card. The case name appears on the front of the card in conjunction with the mailing address.
Required	**4.**	**Recipient Name** - Enter the name of the patient for whom the service is requested, exactly as it appears on the MediPlan or KidCare card.

Required	**5.**	**Recipient Number** - Enter the nine digit Recipient Identification Number assigned to the patient for whom the service is requested. This number is found to the right of the patient's name on the back of the MediPlan or KidCare Card.
Required	**6.**	**Birthdate** - Enter the patient's birthdate. This is a six-digit field. Entry must be in MMDDYY format, with no commas or dashes. For example, a birthdate of February 3, 2001 would be entered as 020301.
Conditionally Required	**7.**	**Inst Set (Institutional Setting)** - An entry in this field is made only when the patient resides in a Long Term Care facility.

Enter one of the following codes to identify the arrangement:

H = Long-Term Care Facility
I = Sheltered Care Facility
L = Other Location, e.g., State Hospital

If the patient does not reside in a long term care facility, leave blank.

Required	**8.**	**Case Number** - Enter the Case Identification Number from the patient's Medical Eligibility Card. (This number is found in the primary portion (front) of the card immediately above the case name and mailing address.)
Required	**9.**	**Recipient Street** - Enter the patient's current street address.
Conditionally Required	**10.**	**Facility Name** - An entry in this field is required only when an entry appears in Item 7 above.
Required	**11.**	**Recipient City** - Refer to Item 9 above.
Conditionally Required	**12.**	**Facility City** - An entry in this field is required only when an entry appears in Item 7 and 10.
Required	**13.**	**Requesting Provider Name** - Enter the name of the physician who is requesting the service.
Required	**14.**	**Request Prov. No. (Requesting Provider Number)** - Enter the state medical license number, UPIN, social security number of the physician who has ordered therapy services.
Not Required	15.	Provider Street - Leave blank.

Required	**16.**	**Provider Telephone** - Enter the office telephone number of the provider who ordered the item. This information is helpful in instances where the Department needs additional information in order to make a decision on the request.
Not Required	17.	Provider City, State, Zip - Leave blank.
Required	**18.**	**Supplying Provider Name** - Enter the name of the provider who will provide the service.
Required	**19.**	**Supply Prov. No. (Supplying Provider Number)** - Enter the supplying provider's Provider Number exactly as shown on the Provider Information Sheet. Use no punctuation or spaces.
Required	**20.**	**Provider Street** - Enter the supplying provider's address.
Required	**21.**	**Provider Telephone** - Enter the telephone number of the supplying provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Required	**22.**	**Provider City, State, Zip** - Refer to item 20 above.
Not Required	23.	Approving. Authority - Leave blank.
Not Required	24.	Disp Date - Leave blank.
Not Required	25.	Approving Authority Signature - Leave blank.
Not Required	26.	Receipt Date - Leave blank.
Required	**27.**	**SERVICE SECTIONS** - The form provides space to request a maximum of three services. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow:
Required		**Req Proc No. (Requested Procedure Code)** - Enter the code which identifies the procedure for which approval is requested.
Required		**Req Qty (Requested Quantity)** - Enter the number of times the service is to be performed.
Required		**Prov Charge (Provider Charge)** - Enter the provider's charge for the services.
Required		**Cat. Serv (Category of Service)** - Enter two digit code.

Required		**Description** - Briefly describe the services or items to be provided. Enter frequency, duration and service time frames with begin and end dates.
Not Required		All remaining items in each service section are for Department use only. Leave blank.
Not Required	28.	Medical Necessity
Required	**29.**	**Supplying Provider Signature** - The form must be signed in ink by the individual who is to provide the service.
Required	**30.**	**Request Date** - Enter the date the form is signed.

Required Attachments:

Physician's order
Copy of initial evaluation or progress summary

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The top, signed copy of the request is to be mailed to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
Post Office Box 19105
Springfield, Illinois 62794-9105

The remaining copies may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider. The service is not to be provided until the approval notification is received.

APPENDIX J-2a
Reduced Facsimile of Form DPA 1409, Prior Approval Request

PRIOR APPROVAL REQUEST

ILLINOIS DEPARTMENT OF PUBLIC AID

Document Control Number

"Completion Mandatory, Ill.Rev.Stat., PA Code, penalty non-payment. Form Approved

CCC

1.Trans | 2.Prior Approval Number | 3.Case Name

4.Recipient Name (First, MI, Last) | 5.Recipient Number | 6.Birthdat | 7.Inst.Se | 8.Case Number

9.Recipient Street | 10.Facility Name

11.Recipient Stat Zip | 12.Facility City

13.Requesting Provider Name | 14.Requesting

15.Provider Street | 16.Provider Telephone ( )

17.Provider Stat Zip

18.Supplying Provider Name | 19.Supply Prov.No.

20.Provider Street | 21.Provider Telephone ( )

22.Provider Stat Zip

23.Aprv.Authorit | 24.Disp.Date | 25. Approving Authority Signature | 26.Receipt

27.SERVICE SECTIONS

1	Req.Proc.Co	Req.Qty.	Prov.Charge	Cat.Serv	Description
DISP STATU	Aprv.Proc.C	Aprv.Qty.	Unit		
0=Deni 1=Aprv.	Total	Begin Date	End Date		Reason For Denial
2	Req.Proc.Co	Req.Qty.	Prov.Charg	Cat.Serv	Description
DISP STATU	Aprv.Proc.C	Aprv.Qty.	Unit		
0=Deni 1=Aprv.	Total	Begin Date	End Date		Reason For Denial
3	Req.Proc.Co	Req.Qty.	Prov.Charg	Cat.Serv	Description
DISP STATU	Aprv.Proc.C	Aprv.Qty.	Unit		
0=Deni 1=Aprv.	Total	Begin Date	End Date		Reason For Denial

28. Medical Necessity

This is to certify that the information above is true, accurate and complete.

29. Supplying Provider Signature | 30.Request Date

DPA 1409 (R-1-92) IL478-1100

APPENDIX J-3

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic J-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix J-3a. The item or area numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

	FIELD	EXPLANATION
1	**PROVIDER KEY**	This number uniquely identifies the provider and is to be used as the provider number when billing charges to the Department.
2	**PROVIDER NAME AND LOCATION**	This area contains the **NAME AND ADDRESS** of the provider as carried in the Department's records. The three digit **COUNTY** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **TELEPHONE NUMBER** is the primary telephone number of the provider's primary office.
3	**ENROLLMENT SPECIFICS**	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **PROVIDER TYPE** is a three-digit code and corresponding narrative which indicates the provider's classification.

ORGANIZATION TYPE is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested By Audits
C = Citation to Discover Assets
G = Garnishment
S = Exception Requested By Provider Participation Unit
T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

4 **CERTIFICATION/ LICENSE NUMBER**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5 **S.S.#**

This is the provider's social security or FEIN number.

6 **SPECIALTY AND CATEGORIES OF SERVICE**

This area identifies special licensure information and the types of services a provider is enrolled to provide.

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:

011	Physical Therapy Services
012	Occupational Therapy Services
013	Speech Therapy/Pathology Services

Each entry is followed by the date that the provider was approved to render services for each category listed.

7 **PAYEE INFORMATION**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single digit **PAYEE CODE**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

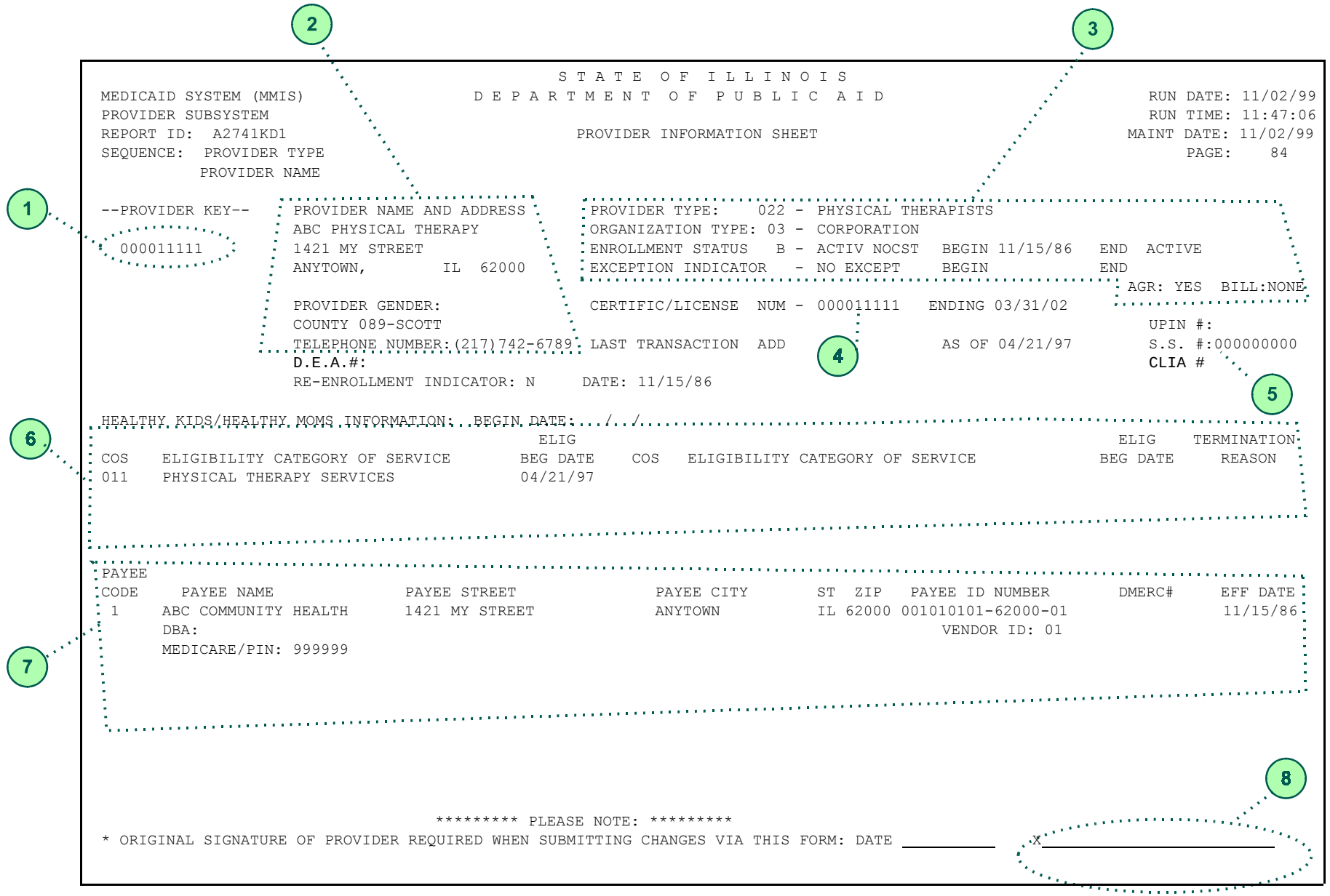
PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

8 **SIGNATURE**

The provider is required to affix an original signature when submitting changes to the Department of Public Aid.

APPENDIX J-3a
Reduced Facsimile of Provider Information Sheet



APPENDIX J-4

INITIAL TREATMENT WITHOUT PRIOR APPROVAL FOR PHYSICAL AND OCCUPATIONAL THERAPY

The following is a list of diagnoses and time for initial treatment without prior approval.

Services for these conditions may be provided during the time or the number of treatments identified, whichever occurs first.

If service is necessary beyond the time or number listed, prior approval will be necessary.

Along with the appropriate diagnosis, the therapist must ensure that a functional deficit exists which impairs the participant's physical well-being and that therapy services have the capacity to alleviate or significantly reduce such deficit, and that without therapy services the participant's functional deficit would not improve.

Diagnosis/Etiology	Initial Time	Number of Sessions
Fracture of vertebral column	1 month	8
Incomplete Cauda Equina syndrom	3 months	39
Spinal radiculopathy	3 months	39
Spinal stenosis	3 months	39
AIDS w/neurological involvement	3 months	26
Amyotropic Lateral Sclerosis	3 months	26
Cerebellar Ataxia	3 months	26
Diabetes w/neurological impairment	3 months	26
Encephalopathy	3 months	26
Gullain Barre Syndrome	3 months	26
Postpolio Syndrome	3 months	26
Meningitis	3 months	26
Multiple Sclerosis	3 months	26
Myasthenia Gravis	3 months	26

Diagnosis/Etiology	Initial Time	Number of Sessions
Parkinsons disease	3 months	26
Spinocerebellar degeneration	3 months	26
Syringomyelia	3 months	26
Quadraplegia	3 months	39
Cerebrovascular accident	3 months	39
Hemiparesis	3 months	39
Hemiplegia	3 months	39
Subarachnoid hemorrhage	3 months	39
Ankylosing Spondylitis	3 months	39
Degenerative joint disease	3 months	39
Dermatomyocitis	3 months	39
Juvenile Rheumatoid Arthritis	3 months	39
Lupus Erythematosis	3 months	39
Osteoarthritis	3 months	39
Psoriatic Arthritis	3 months	39
Rheumatoid Arthritis	3 months	39
Scleraderma	3 months	39
Amputation (upper or lower extremity)	3 months	39
Multiple fractures (upper or lower extremity)	3 months	39
Adhesive capsulitis of shoulder	3 months	39
Brachial Plexus lesion	3 months	39
Compression syndrome	3 months	39
Upper extremity joint contracture	3 months	39
Crushing injury	3 months	39
Degloving injury	3 months	39

Diagnosis/Etiology	Initial Time	Number of Sessions
DeQuervian's disease	3 months	39
Dupuytren's Paralysis	3 months	39
Erbs Palsy	3 months	39
Klumpkes Paralysis	3 months	39
Peripheral nerve injury	3 months	39
Reflex Sympathetic Dystrophy	3 months	39
Muscle rupture	3 months	39
Shoulder (glenhumeral fracture)	3 months	39
Single fracture (wrist, upper or lower arms)	3 months	39
Tendon repair	3 months	26
Tendonitis	3 months	26
Carpal Tunnel Syndrome	3 months	26
Commulative trauma	3 months	39
Lymphedema	3 months	39
Rotator cuff	3 months	39
Shoulder dislocation	3 months	39
Facial and trunk burns	3 months	39
Facial and trunk reconstructive surgery	3 months	39
Arthrogyposis	3 months	39
Hypertonia	3 months	39
Hypotonia	3 months	39
Muscular Dystrophy	3 months	39
Sensory Integrative Dysfunction	3 months	39
Anoxic Brain Injury	3 months	39
Brain tumor	3 months	39

Diagnosis/Etiology	Initial Time	Number of Sessions
Closed head injury	3 months	39
Central cord syndrome	3 months	39
Quadriplegia, quadriparesis	3 months	39
Paraplegia, paraparesis	3 months	39
Upper extremity burns	3 months	39
Upper extremity reconstructive surgery	3 months	39

APPENDIX J-5

GUIDELINES FOR SERVICE NOT REQUIRING PRIOR APPROVAL FOR SPEECH AND LANGUAGE THERAPY

ADULT NEUROLOGICAL DISORDERS

A. DESCRIPTIONS

1. **APHASIA**: An impairment in understanding and use of language. Disturbances may be evident in speech, auditory comprehension, reading, writing, gestures or numerical relationships. It is unrelated to any speech muscle dysfunction.

   Etiology: A result of brain damage from stroke (Cerebral Vascular Accident), head injury, tumors and infection such as meningitis.

2. **APRAXIA:** An impairment of voluntary movements on command due to brain damage in the absence of significant auditory comprehension deficits and not the result of neuromuscular impairment. This category includes:

   a. MOTOR APRAXIA: An impairment in the ability to carry out voluntary motor acts such as writing, gesturing, use of objects, etc.

   b. APRAXIA OF SPEECH: An impairment of controlled voluntary movement of the speech mechanism that verbal expression is usually labored and person may appear to struggle when speaking. Sounds are not always produced accurately.

   Etiology: It is a result of brain damage caused by stroke (CVA), head injury, infection or tumor.

3. **DYSARTHRIA:** A motor speech impairment due to paralysis, weakness or incoordination of the muscles of speech, phonation and respiration.

   Etiology: Dysarthria is the result of damage to the speech muscle control centers in the brain caused by stroke (CVA), head trauma, tumors or diseases affecting muscle control which include, but are not limited to: Cerebral Vascular Accident, Amyotrophic Lateral Sclerosis, Cerebral Palsy, Multiple Sclerosis, exposure to toxins and drugs, Parkinson's Disease, Myasthenia Gravis and Polio.

4. **NON-DOMINANT HEMISPHERE LESIONS:** Difficulty in utilizing language skills effectively and efficiently. Problems in the area of attention, orientation, perception, pragmatics, memory and integration affect the patient's ability to understand, read, write, speak, handle money and perform mathematical calculations.

Etiology: It is a result of brain damage caused by stroke (CVA), head injury, tumor or infection. The damage occurs on the nondominant side of the brain, which in most adults is the right cerebral hemisphere.

5. **LANGUAGE DEFICITS RELATED TO GENERALIZED BRAIN DAMAGE:** Overall depressed language skills with attentional and memory deficits; disorientation to time, person and place; problems with abstract language and reduced ability to organize language and slow processing.

   Etiology: It is a result of brain damage caused by, but not limited to anoxia, encephalitis, multiple CVA's, toxicity, carbon monoxide poison, Parkinson's disease, dementia, Alzheimer's Disease, organic brain syndrome, Korsakoff's Disease, head injury, etc.

B. CRITERIA FOR TREATMENT

Assessment/Evaluation by a licensed speech-language pathologist reveals:

1. Functional deficits in auditory comprehension, speech-language production, reading, numerical relationships, writing or pragmatics,
2. Potential for improvement,
3. No previous outpatient treatment for the most recent episode, or
4. A significant circumstance necessitating a second treatment regimen, including, but not limited to: patient showed significant increase in alertness, motivation or language functioning, treatment course interrupted, etc.

C. LENGTH OF TREATMENT

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 30, individual or group, one hour sessions.

Additional treatment period after reassessment (up to 6 months for each period):

1. Prior approval.
2. 30, individual or group, one hour sessions.

ADULT VOICE DISORDERS
GENERAL

A. DESCRIPTION

Voice disorders in adults and adolescents can include problems of vocal quality, resonance, pitch or loudness. Aphonia (the absence of voice) and aphonic breaks can occur. There can also be breath support/control problems impairing voice production.

Terms frequently used to characterize voice disorders involving problems with voice quality, resonance, pitch or loudness include:

Voice quality: hoarseness, wet hoarseness, roughness, strain, harshness, stridency, strangled, tremor, periodicity, breathiness, whisper, glottal attacks, glottal fry.

Resonance: nasality problems.

Vocal Pitch: too low, too high, too little variation (monopitch), multiple pitches (e.g. diplophonia), too much variation including pitch breaks.

Loudness: weak, overly loud, inappropriate variations.

Etiology: Misuse or improper use/functioning of the vocal mechanism; frequently there is vocal abuse. Sometimes, abnormalities or pathologies of the larynx are present, including but not limited to: nodules, polyps, contact ulcers, papilloma, vocal cord paralysis, bowing of vocal cords, laryngeal edema, chronic laryngitis, stenosis. Some of the above are the direct result of habitual/chronic misuse of the voice. It is recommended that individuals with voice problems/disorders receive laryngeal examination.

B. CRITERIA FOR TREATMENT

Speech-voice Assessment/Evaluation by a licensed speech language pathologist reveals:

1. A voice problem of at least moderate degree,
2. Problems with any two (or more) aspects of voice,
3. No previous voice treatment, or
4. Significant incident necessitating a second treatment regime.

C. LENGTH OF TREATMENT

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 30, one hour sessions.

Additional treatment period after reassessment (up to 3 months for each period):

1. Prior approval.
2. 12, one hour sessions.

D. EXCEPTION

A voice problem of mild degree:

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 12, one hour sessions.

Additional treatment period after reassessment (up to 2 months for each period):

1. Prior approval.
2. 12, one hour sessions.

ADULT VOICE DISORDERS
Related to Laryngeal Cancer

A. DESCRIPTION

Voice disorders related to laryngeal lesions (cancer) can include total absence of voice or problems of voice quality, pitch or loudness. There can also be breath support/control problems impairing voice production secondary to respiratory disorders or tracheostomy.

Additionally, swallowing-eating may be a problem (Refer to Swallowing Disorders).

Terms frequently used to characterize voice problems include:

No voice, aphonia

Voice quality: hoarseness, wet hoarseness, roughness, strain, harshness, stridency, strangled, breathiness, impaired/reduced laryngeal adduction, glottal fry.

Vocal pitch: too low.

Loudness: reduced, weak voice.

Etiology: These voice problems occur in conjunction with various laryngeal lesions (cancer); frequently surgery or radiation is required. The surgical procedures include but are not limited to: total laryngectomy and partial laryngectomy; e.g. supraglottic laryngectomy, vertical hemilaryngectomy, hemilaryngectomy, or subtotal laryngectomy.

B. CRITERIA FOR TREATMENT

Speech-voice Assessment/Evaluation by a licensed speech language pathologist reveals:

1. No voice (aphonia); or
2. Problems with any two (or more) aspects of voice;
3. A problem of at least a mild to moderate degree; or
4. Swallowing problems (Refer to Swallowing Disorders)
5. No previous voice treatment; or
6. Significant incident necessitating a second treatment regime, e.g. dilatation, TEP.

C. LENGTH OF TREATMENT

1. No voice (aphonia), related to total laryngectomy

   a. Esophageal Voice Treatment: Traditional*

      Initial Treatment Period (up to 9 months):

      1. No prior approval.
      2. 45, one hour sessions.

      Additional treatment period after reassessment (up to 3 months for each period):

      1. Prior approval.
      2. 14, one hour sessions.

   b. Esophageal Voice Treatment: Use of a prosthesis, e.g. after tracheoesophageal puncture.

      Initial Treatment Period (up to 3 months):

      1. No prior approval.
      2. 20, one hour sessions.

      Additional treatment period after reassessment (up to 3 months for each period):

      1. Prior approval.
      2. 12, one hour sessions.

   c. Esophageal Voice Treatment: Use of an Artificial Larynx, e.g. electrolarynx.

      Initial Treatment Period (up to 3 months):

      1. No prior approval.
      2. 12, one hour sessions.

      Additional treatment period after reassessment (up to 3 months for each period):

      1. Prior approval.
      2. 12, one hour sessions.

2. Voice problems of quality, pitch, loudness related to partial laryngectomy.

    Initial Treatment Period (up to 3 months):

    1. No prior approval.
    2. 12, one hour sessions.

*Treatment with an artificial larynx and traditional esophageal voice treatment may be occurring at the same time.

    Additional treatment period after reassessment (up to 3 months for each period):

    1. Prior approval.
    2. 12, one hour sessions.

ADULT SPEECH DISORDERS
Related to Oral Cancer

A. DESCRIPTION

Speech disorders related to oral cancer involve impairment of speech intelligibility and include problems of articulation, resonance and rate/prosody. Additionally, swallowing-eating problems are frequently present. Terms often used to characterize these speech problems include:

Articulation: imprecise, distorted, reduced clarity, slurred, sound substitutions-compensations/omissions, reduced or poor intelligibility.

Resonance: nasality, other resonance changes because of changes in the oral cavity, nasal air emission/leaks.

Rate/prosody: slow, too fast for present speech mechanism.

Oral-motor proficiency: limited rate, range or strength of movement of the lips, tongue, mandible, velum.

Swallowing-eating, deglutition: slow, nasal regurgitation, reduced oral motility and drooling, increase in oral transit time, impaired pharyngeal phase, reduced swallow reflex, coughing (food entering airway) aspiration.

Etiology: These speech and swallowing-eating problems occur in conjunction with various oral lesions (cancer); frequently there has been surgery or radiation. The surgical procedures include but are not limited to: total glossectomy, partial tongue resection/partial glossectomy, composite resection, tongue flaps, palatal-maxillary surgery.

B. CRITERIA FOR TREATMENT

Speech-voice Assessment/Evaluation by a licensed speech language pathologist reveals:

1. A speech problem of at least moderate degree,
2. A swallowing-eating problem of a mild degree or worse,
3. No previous speech treatment, or
4. Significant incident necessitating a second treatment regime.

C. LENGTH OF TREATMENT

Initial Treatment Period (3 months):

1. No prior approval.
2. 20, one hour sessions.

Additional treatment period after reassessment (up to 3 months for each period):

1. Prior approval.
2. 15, one hour sessions.

D. EXCEPTION

For a problem of mild degree:

Initial Treatment Period (2 months):

1. No prior approval.
2. 12, one hour sessions.

Additional treatment period after reassessment (up to 2 months for each period):

1. Prior approval.
2. 12, one hour sessions.

SWALLOWING DISORDERS

A. DESCRIPTION

Infants, children or adults exhibiting swallowing and feeding disorders including but not limited to the following: prematurity, neurological disorders (cerebral palsy, degenerative diseases, CVA), oral-motor deficits, oral-sensory deficits, supraglottic laryngectomy or head and neck cancer. One or more of the stages of swallowing may be involved:

Oral: Material place in the mouth, lip seal and formation and manipulation of the bolus. This includes mastication. The tongue propelling the bolus posteriorly until the swallow reflex is triggered.

Pharyngeal: Reflexive swallow carries bolus through the pharynx.

Esophageal: Esophageal peristalsis carries bolus through the cervical and thoracic esophagus to the stomach.

B. CRITERIA FOR TREATMENT

Swallowing evaluation by a licensed speech language pathologist reveals:

1. Children or adults must have difficulty with one or more stages of swallowing.
2. The child or adult must have inadequate oral intake of solids or liquids for nutrition.
3. There must be potential for increasing oral intake.

C. LENGTH OF TREATMENT

Initial Treatment Period (up to 6 months):

1. No prior approval.
2. 36, one hour sessions.

Additional treatment period after reassessment (up to 3 months):

1. Prior approval.
2. 18, one hour sessions.
3. Evidence that treatment plan was evaluated and revised; evidence of progress; or discharge recommendation.

PEDIATRIC/CHILDHOOD DISORDERS
ARTICULATION/PHONOLOGICAL DISORDER

A. DESCRIPTION

ARTICULATION/PHONOLOGICAL DISORDER

The inability to produce speech sounds in the language system adequately, thus reducing intelligibility of speech.

Etiology: Includes, but is not limited to: trauma, cerebral palsy, apraxia, cleft palate, neuromuscular disorders, hearing impairment, mental retardation, emotional disturbances, recurrent otitis media acquired aberrant behavior patterns, brain tumors, oral trauma, oral cancer requiring surgery.

B. CRITERIA FOR TREATMENT

Speech Language evaluation by a licensed speech language pathologist reveals:

1. Articulation/phonological skills fall below those expected for child's chronological age.
2. Disorder negatively affects overall speech intelligibility.

C. LENGTH OF TREATMENT:

Initial treatment period (up to 6 months):

1. No prior approval.
2. 24, one hour sessions.

Additional treatment period after reassessment (up to 3 months for each period):

1. No prior approval.
2. 12, one hour sessions.

PEDIATRIC/CHILDHOOD LANGUAGE DISORDERS

A. DESCRIPTION

Language Disorder will be used here as a broad term to describe certain language behaviors, or lack of same, in a child that are different from the behaviors that might be expected considering the child's chronological age.

Etiologies which cause language disorders or put children at risk, include but are not limited to: head injury, brain tumors, CVA, anoxia, seizures, cerebral palsy, cleft palate, mental retardation, meningitis, hearing impairment, chronic otitis media, emotional disturbances, minimal brain dysfunction, environmental deprivation, failure to thrive, bronchopulmonary dysplasia, fetal alcohol syndrome, encephalitis, respiratory dependent, maternal addiction to controlled substance at time of birth.

B. CRITERIA FOR TREATMENT

Speech Language evaluation by a licensed speech language pathologist reveals:

1. Language skills fall below those expected for the child's chronological age.
2. Those skills may include auditory comprehension, oral expression/formulation, pragmatics, reading comprehension, cognition, numerical relationships or written expressions.

C. LENGTH OF TREATMENT:

Initial treatment period (up to 6 months):

1. No prior approval.
2. Treatment should begin as soon as the problem is identified.
3. 24, one hour or 48, 1/2 hour group or individual treatment sessions.

Additional treatment period after reassessment (up to 6 months for each period):

1. No prior approval.
2. 24, one hour or 48, 1/2 hour group or individual treatment sessions.

Typically, treatment can be expected to be necessary for twelve months or more depending upon the etiology or severity of the disorder.

PEDIATRIC/CHILDHOOD DISORDERS
VOICE DISORDERS

A. DESCRIPTION

Voice Disorders: A term used to refer to defects in one or more aspects of voice production which are related to abnormalities in size, shape, tonicity, surface conditions and muscular control of the phonating and resonating mechanisms.

Etiology: These voice problems occur in conjunction with various laryngeal pathologies or abnormalities including but not limited to: disease, trauma, surgery, abuse, stenosis, nodules, polyps, cleft palate, congenital webs, tracheostomy, tracheal malsia, psychogenic reasons.

B. CRITERIA FOR TREATMENT

One or more aspects of voice is judged to be abnormal as assessed by a licensed speech language pathologist.

C. LENGTH OF TREATMENT:

Initial treatment period (up to 6 months):

1. No prior approval.
2. Treatment should begin as soon as the problem is identified.
3. 24, one hour sessions.

Additional treatment period after reassessment (up to 3 months):

1. Requires prior approval.
2. 10, one hour sessions.

NONSPEAKING CHILDREN

A. DESCRIPTION

Nonspeaking children: Individuals having no consistent functional means of communications or those individuals who demonstrate inconsistent functional skills in speaking, writing or gestures due to a variety of speech, language and voice disorders.

Etiology: includes but is not limited to the following cerebral palsy, cerebral vascular accident, head trauma, brain tumor, spinal cord injury (requiring a trach), muscular dystrophy, respiratory disorders, tracheostomy, mental retardation, autism, deaf or hearing impairment.

B. CRITERIA FOR TREATMENT

Evaluation by a licensed speech language pathologist reveals:

1. Speech and Expressive Language Skills

    a. Absence of functional speech and language, or
    b. Markedly reduce intelligibility of speech, and
    c. Nonfunctional written or gesture skills.

2. Cognitive Skills

    a. Fair to good attention, memory, orientation and potential for new learning.
    b. Recognition of symbols, pictures, words, alphabet letters or numbers, or recognition of gestures and manual signs.

3. Behavior

    a. Cooperative and receptive to treatment
    b. Attempts to communicate to others or displays potential
    c. Not destructive or harmful to self or others

4. Intervention

    a. Intervention requires the utilization of an alternate/augmentative communication system to facilitate further development in communication.

5. Environmental Factors

   a. Family or supportive individuals must be receptive toward the nonspeaking individual's use of an alternative/augmentative communication system (ACS).
   b. The existence of education or vocational goals, or has potential for benefitting from educational experience via the introduction of an ACS.

C. LENGTH OF TREATMENT:

Initial treatment period (up to 6 months):

1. No prior approval.
2. Training with a temporary ACS (up to 3 months)
   a. 15, one hour sessions
3. Training with a permanent ACS (up to 6 months)
   a. 30, one hour sessions.

Additional treatment period after reassessment (up to 3 months for each period):

1. No prior approval.
2. 24, one hour sessions.

Reassessment/Recheck (following discontinuation of formal training):

Periodic rechecks/follow-up sessions are recommended and conducted in 2 hours of sessions:

1. No prior approval
2. To monitor the patient's use of his ACS
3. To reassess his current communicative needs and capabilities
4. To determine if further upgrading or modification is required
5. To assess with an advanced ACS

Prior approval for training with the newly recommended ACS (based on documented results or reassessment/recheck procedures):

1. No prior approval
2. 30, one hour sessions within a 6 month period
3. Treatment to continue in 12, one hour session blocks should be granted based on documented progress.